MONTHLY CASE MANAGEMENT BILLING & REPORTING FORM

ND DEPARTMENT OF HUMAN SERVICES
LIHEAP

SFN 339 (3-2006)

The Privacy Act of 1974 (P.L. 93-579, Section 7) requires the following information be provided when individuals are requested to disclose their social security number. Disclosure of your social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

Clear Fields

NOTE: A separate form for each county per month must be submitted to each referral source.

Name: (C.A.A.)			To: (County Social Service Board)	
Address of Payee:			Referral Source: CSSB/LIHEAP	
City:	State:	Zip Code:	Month/Year of Service:	Cost Per Hour:

NAME AND SOCIAL SECURITY NUMBER	LIHEAP	REVIEWED BY (Initials)	NUMBER OF CONTACTS	UNITS OF SERVICE 1/4 Hr. = 1 Unit	TOTAL COST
Name: Social Security Number:					
Name: Social Security Number:					
Name: Social Security Number:					
Name: Social Security Number:					
Name: Social Security Number:					
Name: Social Security Number:					
Name: Social Security Number:					
Name: Social Security Number:					
Name: Social Security Number:					
Name: Social Security Number:					
				TOTAL	

I hereby certify that this is an accurate statement of the contacts and units of service delivered. (Attach monthly data report).

Community Action Agency Director:	Date:
County Representative:	Date:

DISTRIBUTION CAA: Make original and two copies. Sign all and send two copies to CSSB. Retain third copy for agency records.
CSSB: Sign the two copies and send one to the State LIHEAP Office. Retain one copy for agency records.